

Practice audit in gastroenterology – the route to improving quality and safety

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Practice audits provide insight into quality of clinical care and may drive improvement (1). Increasingly, such practice audits are driven not only by individual physicians but by peer groups and national specialist societies. In gastroenterology and hepatology, several areas of procedural practice provide excellent opportunities for peer-comparator practice audit such as colonoscopy, gastrointestinal bleeding, endoscopic retrograde cholangiopancreatography, endoscopic ultrasound fine-needle aspiration, liver biopsy and detection of Barrett's esophagus. In addition, nonprocedural practice in gastroenterology such as inflammatory bowel disease and management of chronic diarrhea, dysphagia, viral hepatitis and dyspepsia offer some of the areas of practice that will benefit from peer-comparator practice audits. Increasingly, both personal benchmarking and unit-based benchmarking are becoming equally important to ensuring delivery of high-quality care. This will strive to avoid unwarranted variation in practice through insight, education and training.

Colonoscopy practice is leading the development of quality assurance in gastroenterology, being driven by colorectal cancer screening in the asymptomatic population. In the present issue of *The Canadian Journal of Gastroenterology*, Armstrong et al (2) (pages 13-20) report the finding of the Canadian Association of Gastroenterology (CAG) colonoscopy audit. The data were uniquely collected electronically in real time. While the mean cecal intubation rate was 95%, it was worrying that 42% of colonoscopists reported a mean withdrawal time of less than 6 min. Ten per cent of participants had a mean cecal intubation rate of less than 85%. Other factors that may affect polyp detection such as proper positioning of patients during withdrawal and scrupulous cleaning of the colon by water spray were not reported in this audit. Ten per cent of participants reported polypectomies in 13% or less of their colonoscopies. The linking of processes such as colonoscopy withdrawal time to outcome and polyp detection rate provides a strong validation of such a practice audit. The findings may help focus training programs on improving withdrawal time and polyp detection rates by raising awareness in colonoscopists. The outcome of such improvement will be more effective colon cancer screening programs for the population.

An important aspect of colonoscopy practice is the knowledge of guidelines such as the most appropriate interval for follow-up colonoscopy after polyp removal or the recognition of the emerging importance of serrated polyps (3). These impact on quality of practice and resource use, and should, therefore, be regulated as closely as the use of drugs in medical practice. Individual variation in practice should be minimized and monitored in areas of practice underpinned by evidence-based national guidelines such as the recently published CAG guidelines (4). Surveillance colonoscopy continues to be underused in high-risk patients and overused in average-risk patients (5). In the face of mounting wait times for colonoscopy, appropriate allocation of this scarce resource is pivotal to favourably affecting outcome. Gastroenterology training programs must focus on quality of endoscopy training using validated benchmarks, but continuing peer-comparator audits are essential in maintaining and improving quality – it is important that such processes are inclusive of all practicing endoscopists both in academic and community settings.

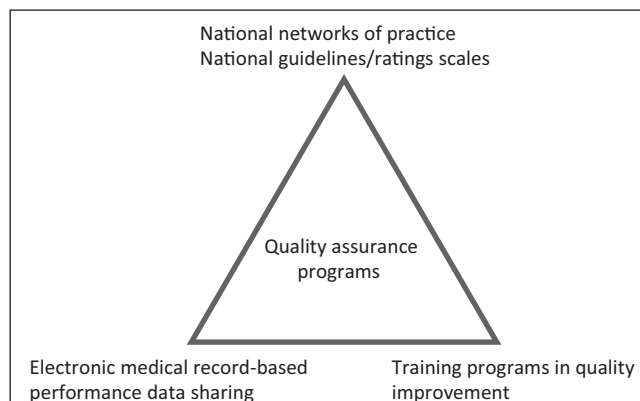


Figure 1) Elements of peer-comparator quality assurance programs

The *Canadian Journal of Gastroenterology* is striving to focus on quality assurance and safety as key areas of research and audit. These are also important national roles for the CAG and the Canadian Association for the Study of the Liver. The structural requirements necessary for quality improvement are best underpinned by national specialist organizations (Figure 1). The public requires continuous demonstration of development, maintenance and measurement of professional competencies by gastroenterologists in an ongoing, structured manner. Increasingly, the government, as payer, will demand evidence of high-quality practice before investing their resources in health care. The *Journal* has already published several articles on colonoscopy training and quality improvement. Quality assurance in colonoscopy is serving as a model for developing quality assurance programs more widely in gastroenterology and hepatology. Medical quality assurance will be an area of research and development that will characterize the *Journal* and provide it with a distinctive feature. The appointment of a specialist editor in quality assurance indicates the commitment of the *Journal* to publishing high-quality articles in this area as a pivotal theme.

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